INTEGRATED CARE FOR THE DUALLY ELIGIBLE

Support And Services at Home (SASH) is an integrated system of care that has been under development in Vermont for several years. SASH has been designed with prospective participants and partner agencies. Last year SASH became a part of the Multi-payer Advanced Primary Care Practices (MAPCP) demonstration under the Blueprint for Health. Over a three year period SASH will be available to 6,120 Medicare beneficiaries. If the quality and cost reduction outcomes are achieved, AHS Secretary Sebelius has the authority to make this demonstration permanent. This would make SASH available to all 96,000 Medicare recipients, including the 23,000 dually eligible Vermonters, the majority of whom are elderly.

SASH was designed initially serve low income seniors living in subsidized housing – a population where the correlation between poverty and chronic conditions is evident. The theory was that affordable housing settings not only offer an efficient location for care management and prevention programming, but it is also home to low income Vermonters – a high number who are dually eligible for Medicaid and Medicare. SASH recently expanded to Medicare recipients living in community settings including a wide range of ages, incomes and residential settings.

SASH supports medical homes and community health teams by forming regionally designed Collaboratives among the key agencies that provide acute, primary, mental health and long term care services for the Medicare and Medicaid population. A SASH Collaborative will exist in all counties by January 2013, just when the Integrated Care proposal would begin implementation. Over the next year Vermont will make significant investments in health information systems, technology and training infrastructures. As Vermont builds one system of care, let's include the dually eligible.

As of December 1, 2011, SASH Collaborative Agreements exist in Bennington, Caledonia, Chittenden, Rutland, Washington and Windham counties. By January 2013 SASH Collaboratives will exist in Addison, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, and Windsor counties.

The parties to these Memorandum of Understanding include the provider agencies currently caring for the Dually Eligible population. Most regional collaboratives include:

- The local hospital
- The designated community mental health agency
- The VNA
- The Area Agency on Aging
- Residential Providers
- Other organizations including funders, colleges, and PACE

A Better Way: spread the risk and increase supports for Vermont's lowest income residents

The number of Dually Eligible Vermonters in each county is relatively small, increasing the risk for providers and capping the scale of regional delivery systems. In contrast, SASH is designed to be scalable to serve all 96,000 Medicare recipients – over 4 times the Dually Eligible population. Because the SASH population includes all Dually Eligible Vermonters – it makes sense to use that single system to

support the Dually Eligible. Creating a separate delivery system for **4,432** dually eligible in Chittenden County, or for the **1,450** dually eligible in Caledonia County, would be duplicative of SASH.

SASH engages the underutilized asset of housers to support a public health, population based approach to care management. We know that the major determinants of health have to do with behaviors, environment and social circumstances – while the formal health care system drives only 10% of health outcomes. In other words, one's health status is more likely to be shaped at home than at your medical home. And home for the Dually Eligible is often the congregate housing provided by nonprofit housers, or homeownership opportunities offered by Land Trusts, or community housing subsidized by the Section 8 voucher program available through public housing authorities.

In 2010 Vermont was the 26th oldest state in the country – by 2030 it will be the 8th oldest state. All trends point to a much higher level of health needs among Vermonters "aging in place". We know that 49% of the residents at the SASH pilot site failed the cognitive screen. When the resident population in independent housing looks more like a nursing home, nonprofit housing providers must adapt.

In the face of increasing needs and decreased funding, SASH was designed to reduce costs, avoid duplication, and take advantage of several one-time infusions of federal funding including building the Health Information Exchange, incentivizing a quality driven medical home network, and investing in Broadband and home based technology. Building this infrastructure will benefit all Vermonters.

How the Dually Eligible could be served by the Blueprint/CHT/SASH system

Scenario #1: The most integrated and sustainable approach is illustrated in Attachment 1. Under this scenario all costs would be managed by new regional entities built on the SASH Collaborative. Payment would go to this new entity and allocated to provider members based on quality outcomes. The new entity bares all risk, with a stop loss safety net for extremely high cost cases.

Scenario #2: Under this scenario the state manages the high costs centers (hospitals, nursing homes, pharmacy, etc) while all other costs are managed by a new entity formed by the members of the SASH Collaborative in the region (see Attachment 2). Risk is absorbed by the state and savings shared.

Scenario #3: The state's current proposal is to pay for the costs of Blueprint medical homes, community health teams and SASH supports to the Dually Eligible population. Under this scenario the state accepts bids from CIPs to provide all services that are not managed by the state. This approach recognizes the core value of Blueprint/CHT/SASH and pays for it as it would other "utilities"; however, all other services would be provided by an entity offering services parallel to SASH (see Attachment 3).

The SASH Collaboratives are an early step in integrating agencies. If Vermont is to achieve true payment reform, these Collaboratives will need a more mature organizational structure that works for all partners. If these more formalized structures can deliver on quality care and significant cost savings, then Vermont will be well positioned to provide a single health care system to all Vermonters.

Revised DRAFT for WORKGROUP DISCUSSION PURPOSES
Revised: 12.5.11

1

CMS Medicare / Medicaid $$

State of Vermont

State Manages Funds:

- **All costs for people not enrolled with a CIP**
- **Blueprint payments for primary care physicians, community health teams, SASH**
- **Following costs for people enrolled with a CIP:**
  - Inpatient / Outpatient
  - Skilled Nursing Facility
  - Physician Office visits
  - Lab Tests
  - Pharmacy
  - DME

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- Transportation
- Substance Abuse Services
- Psychiatry
- Other

Capitated Integrated Providers (CIP) (***Contracted via RFPs***):
- Existing Providers
- Existing Peer-Directed Organizations
- New Organizations or Alliances

Responsible (thru direct provision or sub-contracts) for:

Services for people enrolled with a CIP:
- *Development of Individual Plans and Budgets and provision of all services within them, which may include:*
  - Care Coordination for services in Plan
  - Coordination with medical home / other medical services (including Blueprint Community Health Teams)
  - Nursing (not facility or physician-office based nurses)
  - Nurse's Aide
  - Personal Care
  - Therapies
  - Respite
  - Home-maker
  - Community Supports
  - Housing supports, including crisis housing
  - Residential Care / Assisted Living
  - Crisis services (24/7)
  - Assistance to access Public Benefits
  - Medication Management
  - Psychiatry / Mental Health Services
  - Employment Supports
  - Hospice and other palliative care
  - Care transitions
  - Individually identified flexible supports
  - Peer Supports

Required Service Delivery Model Options:
- ***Self-Management***
- ***Provider Care Coordination***
- ***Blended Model***

Provider Payments and Individual Plans / Budgets
- State develops X levels of case rates based on 3 year historical Medicaid / Medicare claims data
- State pays Integrated Providers a capitated payment based on case rates for their Dual beneficiaries
- Integrated Providers use these capitated funds to work with the individual to develop their Individual Plan and Budget based on needs (e.g., Flexible Choices, DS models)

Shared Savings / Incentives:
- State assumes X% savings across all state-managed services at beginning of demonstration, and includes X% in initial payments to Integrated Providers; remainder is used to invest in needed infrastructure, new benefits
- State monitors Integrated Provider performance (using Blue-print-like incentive measures – e.g., quality, access, satisfaction, outcomes)
- If Integrated Providers show savings for their consumers, get X% of savings based on performance and X-Y% must be passed on to Individual Budgets; state uses remainder for new services / benefits

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CMS Medicare / Medicaid $$

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2

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3

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